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Potential Uses of Food Aid to Support HIV/AIDS Mitigation Activities in Sub-Saharan Africa

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Food and Nutrition Technical Assistance Project
Academy for Educational Development 1825 Connecticut Ave., NW, Washington, DC, 20009-5721
Tel: 202-884-8000 Fax: 202-884-8432 E-mail: fanta@aed.org Website: http://www.fantaproject.org

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Academy for Educational Development
1825 Connecticut Avenue, NW
Washington, D.C. 20009-5721
Tel: 202-884-8000
Fax: 202-884-8432
Email: fanta@aed.org
Website: www.fantaproject.org

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASO	AIDS service organization
CA	Cooperating Agency
CBO	Community based organization
CS	Cooperating Sponsor
FANTA	Food and Nutrition Technical Assistance Project
FAO	Food and Agriculture Organization
FFW	Food for work
HIV	Human Immunodeficiency Virus
IGA	Income-generating Activity
NGO	Non-governmental organization
PHN	Population, Health, and Nutrition
PLWHA	Person/People Living with HIV/AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
WFP	World Food Program

INTRODUCTION

The HIV/AIDS pandemic reaches into most social and economic aspects of life in at least half the Sub-Saharan African countries. In responding to the impacts of the pandemic on households, communities, businesses and national institutions, USAID has adopted a multi-sectoral strategy that incorporates the strengths of its many programs.

This paper examines whether and how food aid programs might support the Agency's overall strategy and strengthen the ability of service providers and families to cope with the multiple impacts of HIV/AIDS. This paper discusses options for developing strategies and interventions for using Title II food aid to mitigate the impact of HIV/AIDS, discusses where food aid may not be an appropriate option and concludes with recommendations for action.

Interviews with food security and HIV/AIDS stakeholders in the United States, Kenya and Uganda in mid-1999, supplemented by a review of the literature on both the impact of HIV/AIDS and coping strategies used by households and communities provides the basis for the analysis and recommendations. The focus of the field visits and interviews was to identify conditions under which external food aid can be used to help mitigate the impact of HIV/AIDS on the food security situation of:

- Households with family members afflicted with HIV/AIDS
- Households with children orphaned by the death of one or both parents from HIV/AIDS including households headed by widows and orphaned children themselves
- Communities affected by the multiple burdens imposed by the pandemic.

FOOD SECURITY AND HIV/AIDS IN KENYA AND UGANDA

Food Security in Kenya and Uganda

Both Kenya and Uganda are classified by FAO as low-income food deficit countries. USAID defines food security based on three components: food access, food availability, and food utilization. The conditions in Kenya and Uganda indicate that each country is characterized by food insecurity. National agricultural and marketing policies, weather, and civil strife influence food access and availability. In urban areas, food is usually available but a nutritionally adequate diet is too costly for at least one-third of households. Rural households remain heavily dependent upon timely and adequate labor inputs and some sources of cash income to remain food secure throughout the year. The nutritional status of children under 5 years is also an indicator of household food insecurity. In Kenya, 23% of children under 5 years of age are underweight and 34% are stunted. In Uganda, the equivalent figures are 26% and 38%, respectively (UNICEF, *The State of the World's Children 1998*). To address these issues, current USAID Title II-funded programs in Kenya and Uganda include income generation through micro-credit, agricultural training, infrastructure development, maternal and child health, and direct food distribution to displaced persons.

HIV/AIDS Situation in Kenya and Uganda

In 1992, an estimated 30% of adults in Uganda were HIV-infected; since then, a strong national response has helped lower national prevalence to 12% of adults as of 1998. Despite the significant decline in infection rates, AIDS remains the leading cause of death among adults and an estimated 1.7 million children have lost their mother or both parents to the pandemic. Uganda currently has the highest number of AIDS orphans in the world.

About 1.9 million Kenyans are HIV-positive, although fewer than 15% are aware of their sero-status (UNAIDS). The national prevalence rate is 9% of adults, but rates at least twice that high are found in western and central parts of the country. Hundreds of thousands of children have been orphaned by the pandemic, and as a result, they withdraw from school.

The pandemic is concentrated mainly in adolescents and young adults. For example, an estimated 70% of HIV infected persons are between the ages of 14-25 years. Numerous analysts have noted the growing losses to households, companies, and national economic structures because AIDS strikes deeply among some of the most productive and newly trained members of society.

> "AIDS has affected the food security of people living with HIV/AIDS (PLWHA) in many ways—people have less energy when they become sick and cannot work the land which compromises their productive potential. Family heads fall victim and as they deteriorate, they lose strength to produce food which leaves an increased burden on children…also PLWHA's demand for food increases despite not having the money to purchase it."
>
> -Staff member, Private Voluntary Organization in Kampala, Uganda

HIV/AIDS impacts food security and nutritional status in numerous ways including:

- PLWHA frequently are unable to work for increasingly long periods of time, undermining either (or both) earnings and food production activities, and eventually creating a gap in household labor and earnings;
- Family members are drawn away from production or income generation activities to care for sick relatives;
- Households divest tangible assets, savings, and income for medical care rather than productive activities;
- Children are withdrawn from school because of lack of resources to pay school fees, to care for sick relatives and to generate income;
- Constraints on household labor result in changes in agricultural production, including reduction in the area cultivated, shifts to less labor intensive crops and reductions in livestock;
- There is a loss of inter-generational knowledge about crop and livestock production methods;
- There is increased malnutrition among children in households affected by HIV/AIDS; and

- There is an increased susceptibility to other illnesses (for both HIV-infected and non-infected people) as food intake declines.

The impact of HIV/AIDS has contributed to marked reversals in indicators of economic and social well-being. These changes include:

- Increases in household and community poverty rates;
- Declines in commercial agricultural and non-agricultural firms productivity due to absenteeism, losses of trained workers (even within businesses that use lesser-skilled employees), and increases in benefit expenses;
- Stresses on social institutions, such as extended family structures to cope with changes wrought by the pandemic;
- Erosion of several decades of advances in health and education.

The HIV/AIDS pandemic will significantly impact the ability of donors, governments, CSs, and NGOs to sustainably improve food security for households and communities in many countries in Sub-Saharan Africa.

STRATEGIES FOR LINKING FOOD SECURITY WITH HIV/AIDS MITIGATION

Food security and HIV/AIDS specialists in both Kenya and Uganda agreed that the crises generated by the pandemic may create opportunities for food aid to play a positive role in mitigating the impact of HIV/AIDS among households and communities. Similarities with other food emergency situations are characterized by worsening food security due to a loss of access to livelihood and food and increasing vulnerability to malnutrition and death. The onset can be rapid or move more slowly with households disposing of productive assets, communities being disrupted and the coping mechanisms failing to deal with shocks.

Responses by households to HIV/AIDS include: changes in diet, sale of assets, out migration, hiring out of household labor to other households and the withdrawal of children from school. Also, like the onset of hunger conditions, the HIV/AIDS pandemic steadily erodes household coping mechanisms over the long run.

Development processes should build on community participation so that responses to HIV/AIDS mitigation assist in reestablishing household and community food. The prevention and mitigation of HIV/AIDS impacts requires inputs to support local and regional development. The USAID strategy for assistance links short term relief to development in the belief that natural, environmental, civil and other emergencies will be less frequent and less damaging if the vulnerability of populations is mapped and plans are prepared for responses.

While sharing features with other situations in which food aid is used as an option for mitigating impact, the HIV/AIDS pandemic has several distinctive features. First, HIV leads to AIDS which is a fatal disease; however, early diagnosis and access to food and basic care can prolong life and keep a person healthy and productive for a longer period of time. Second, because HIV transmission is primarily sexual and numerous myths have built up around the infection, negative value judgements about HIV-infected individuals (and often their family members) are common.

Increasingly, communities are addressing the stigma associated with HIV/AIDS, but individuals are often reluctant to be tested for the virus or to confide their HIV status to family or friends. More often, testing and counseling services are unavailable. Thus, targeting food aid is hindered by the fear of infected people to self-identify as well as the stigma imposed by communities. Third, too little is known about shorter and longer term food and income needs of infected individuals and affected households. There is a growing body of evidence from pilot and community experiences to draw upon in designing mitigation interventions. Because of the dynamic of the pandemic, however, interventions are often reactive and not coordinated with needs.

Stakeholders noted possible mitigation interventions for preventing households from divesting productive assets to meet nutrition and consumption needs that parallel other food emergency situations including:

- Providing selected vulnerable groups (e.g., PLWHA) with special diets to sustain energy and their immune system;
- Targeting children vulnerable to stunting;
- Targeting female and child-headed households with basic food rations.

Income was noted by many stakeholders as a primary need of PLWHA, of households affected by HIV/AIDS, and among female-headed households affected by HIV/AIDS. Many of the latter, who knew or feared they were HIV-positive, were especially concerned about protecting the future security of their children.

> "Once someone has HIV, the whole family is affected…the small amount of money produced goes for treatment."--AIDS Service Provider in Nairobi, Kenya

Strategies that are developed for using food aid as one intervention to mitigate the impact of HIV/AIDS should take into account the following inter-related factors:

The experiences of both urban and rural community-based organizations in Africa will need to be incorporated into addressing the impact of HIV/AIDS. These organizations do not have all the answers, nor are they always free from the negative judgements surrounding HIV/AIDS in the larger society. However, their experiences and ability and willingness to support community members in need are strengths to be utilized in the coordination of food distribution.

The term community is often used to refer to a geographic unit. In responding to HIV/AIDS the term can assume a wider definition, incorporating the workplace community, religious congregations, social and sports clubs and established community-based groups like micro-credit and income-generating societies.

Targeting individuals, households and communities for food assistance is a challenging process and will require flexibility in eligibility criteria and distribution structures. Like other poverty alleviation programs, there are justifiable issues concerning dependency

and the possible misallocation of food to people without extraordinary need, and these may not be easily resolved in the context of food aid for HIV/AIDS mitigation.

Stakeholders expressed concern that food aid distribution would result in the identification of individuals or households affected by HIV/AIDS, with resultant stigma and possible discrimination. They suggested that the level of awareness of communities about HIV/AIDS in communities and its impact be among the criteria for targeting. However, it is unclear how judgements about awareness will be made or measured and periodically reviewed.

Determining when to intervene with food aid and at what level (e.g., direct to individuals or households, households with a person living with HIV/AIDS or those that have lost one or more family members) will require established, but flexible, criteria. The sequential and cumulative impact of HIV/AIDS on households and communities varies, in terms of the number of members infected, the timing of the infections, and the timing of the onset of symptoms associated with full-blown AIDS. Issues to be considered include such questions as: At what point (and for how long) would food assistance be most critical for PLWHA and affected households? When would the provision of food aid be most useful to prevent negative coping strategies? When would food aid be least likely to have negative repercussions? When should direct food assistance end to households?

The purpose and form of food aid will vary with target groups and the timing of interventions. In many instances, food aid can contribute to improved diets for PLWHA and immediate family members and for households without adequate resources to purchase or produce needed food (such as female- and adolescent-headed households). In other cases, food aid can serve longer term household and community needs by cushioning against loss of assets or permitting existing income to be used for education or purchase of income-producing inputs.

Most respondents in both Kenya and Uganda expressed the opinion that food aid to mitigate the impact of HIV/AIDS on households and communities needs to be delivered as part of an integrated package of services. Also, they emphasized the importance of strengthening community participation, especially of PLWHA, in the design of food aid programs.

APPROACHES FOR LINKING FOOD SECURITY WITH HIV/AIDS MITIGATION

There are no well-tested approaches for using food aid to mitigate the impact of HIV/AIDS on individuals and communities. However, experience from food security programs using food and other resources provide guidance to develop models or approaches. Experiences from complex emergencies or natural disasters, such as prolonged drought, provides insights for more effective and efficient use of food aid.

In terms of identifying the levels of food aid needed for PLWHA and affected households, appropriate dietary needs of PLWHA have been developed by international agencies and a number of indigenous NGOs including NGOs run by PLWHA. Further, there is a growing body of documented and assessed experiences in providing home-based care. These experiences include basic medical, support and sanitary factors, as well as dietary needs. In addition, money,

or its equivalents, like medical care and drugs, is cited as a prevailing need for PLWHA and affected households. The purchase of pharmaceuticals and special dietary supplements is either prohibited under USAID regulations or prohibitively expensive. These challenges provide an opportunity for coordination of donors, the private sector, and service providers to make medical care and drugs more readily available.

In terms of the approaches for using food aid to support HIV/AIDS mitigation activities, there is less experience. In both Uganda and Kenya, food and feeding programs have been used to attract clients for care, counseling, training, or income-generating activities. In Kampala, Uganda, for example, a pilot project supported by WFP used food as an incentive for street children (many orphaned by AIDS) to participate in vocational training programs. In other instances, food programs offered general relief to PLWHA and their families and helped safeguard existing assets which otherwise would be used to acquire food. Food-for-work (FFW) projects in Uganda have been used as an inducement to draw people to specific community-based activities and can be adapted to specific needs of HIV-infected individuals (constructing a hospice or day-care center for PLWHA, for example). In Kenya, several AIDS service organizations use donated food to run feeding programs for HIV-positive individuals and families affected by HIV/AIDS. These examples are not formalized in the sense of being able to consistently offer these services to a select or growing target population.

The integration of food assistance into longer-term development efforts is an important action. Such integration may require that some activities be supported with resources from outside of Food for Peace. Thus, food security approaches for HIV/AIDS mitigation may incorporate one or more of the following:

- income-generating activities (IGAs);
- agricultural intensification;
- vocational skills training;
- community-based psychological support;*
- community insurance schemes to cushion anticipated household deaths;*
- to reduce risk of stigmatization, general targeting need not be limited to households affected by HIV/AIDS;
- feeding programs at schools and hospitals to maintain attendance and adequate levels of care;
- asset replacement.*

Other options will emerge as approaches are refined.

In general, non-emergency food aid may be used for two purposes: 1) general relief/humanitarian assistance and 2) sustainable food security activities. General relief/humanitarian assistance may be needed specifically for groups such as PLWHA in institutions and orphans in institutions or street children as a social safety net program. Also, other groups such as households with elderly grandparents taking care of orphans may need a social safety net. Other food security interventions that promote sustainable development, such as intensifying agricultural production should be implemented with households that have productive members who will contribute to

* Other resources would be required to carry out the activity.

the livelihood security of the household. For example, in the case of home-based care for orphans, food aid may be utilized in the short term to assist the household with the additional food consumption needs but participation in other interventions such as programs that offer vocational skills should be encouraged for longer term development.

It is important to note that persons who are identified as HIV positive are productive members of society until they begin to become ill with opportunistic infections. Every effort will need to be made to provide access for their participation in productive activities in order to sustain their livelihood. Policymakers and program planners will need to examine the social environment and introduce interventions that will reduce stigma and isolation of HIV positive individuals.

Tables 1 and 2 describe some of the mechanisms by which food aid can play a supportive role. As noted above, the level of community awareness of the implications and impact of HIV/AIDS and willingness to respond will influence the effectiveness of directly supporting HIV/AIDS affected households. In order to effectively reach individuals, households and communities in need of food assistance, a set of criteria must be developed for groups affected by HIV/AIDS. Table 1 suggests types of interventions for several likely target groups based on an assessment of social awareness and supportiveness. A supportive social environment is characterized by strong political commitment at all levels in addressing HIV/AIDS, low levels of active discrimination and minimal stigmatization of PLWHA or households affected by HIV/AIDS. As a criteria, "social environment" (i.e., sensitization, awareness, commitment of resources) will have to be tested in a variety of social situations and over time.

Because of the unique nature in which HIV/AIDS will affect a person and their household, the type of food security interventions will vary based on the changing needs of each group over time. Table 2 suggests interventions for three broadly defined timeframes. The table shows the likelihood that suggested interventions will extend beyond and overlap with the initial time period because objectives (such as food to attract clients for skills training) may not be achieved within the timeframes or because specific food needs would still exist.

Table 1: Potential Uses of Food Aid by Social Environment

Status of individual and/or households	Social environment supportive	Social environment negative
PLWHA in institutions	General institutional feeding programs and awareness	General institutional feeding programs and awareness
PLWHA Affected household members	Food to maintain consumption levels of HH members; special dietary needs of PLWHA	General (not targeted) distribution, such as institutional feeding (i.e., schools, hospitals); inclusion in community IGA
HH with productive members after death of PLWHA	Short-term (6 months) food assistance as safety net; feeding programs at schools; food rations inMCHN programs; IGA	Short-term (6 months) food assistance; feeding programs at schools; IGA; promoting greater awareness and sensitization to HIV/AIDS issues
HH headed by widows, children or elderly after death of PLWHA	Long term (24 months) food aid; school feeding; home care; food for training activities	Food aid to attract clients for testing and counseling, to increase local understanding and awareness, and to build infrastructure (e.g., day care and hospice centers) to assist PLWHA and affected HH
Orphans with home-based care (relatives/guardians)	School feeding; IGA; skills training; income transfers	Promoting greater awareness and sensitization to HIV/AIDS issues
Orphans in institutions	Food aid to assist with costs of institutional care	Food aid to assist with costs of institutional care
Street children (orphans)	Food to attract clients for skills training; community-based feeding programs; vocational training	Generalized feeding programs for all street children

Table 2: Potential Food Security Interventions

Status of individual and/or households (HH)	Options for Interventions: Short-term (<6 months)	Medium-term (6-24 months)	Long-term (>24 months)
HH with PLWHA:			
PLWHA	Food to meet special dietary needs →		Institutional distribution: hospitals and hospices
Other HH members	Food to maintain consumption; IGA →		
HH with productive members after AIDS death in HH	Food for safety net	Community-planned food assistance combined with locally available foods	
	Take home rations through MCHN Programs (HH with young children); school feeding; IGA →		
HH headed by widows, children, elderly	Food for safety net →		
		Food to attract clients for vocational and agricultural skills training	
	School feeding →		
Orphans with home-based care (relatives/guardians)	IGA; skills training; school feeding →		
Orphans in institutions	Food aid to assist with costs of care →		
Street children (orphans)	Food to attract clients for skills training; community-based feeding programs →		
Other HH in community (prevention strategy)	Food aid to attract clients for education and testing, and to increase understanding and awareness →		

CONDITIONS WHERE FOOD AID MAY NOT BE A DESIRABLE INPUT

There will be situations where providing food aid is not an appropriate or desirable response. Examples include:

- Where the risk is high of stigmatizing PLWHA or affected households through food distribution, planners will have to carefully weigh the advantages and disadvantages;
- When short term interventions cannot be sustained to match longer-term needs;
- When individuals or affected households are able to meet their own food needs;
- When cash is more appropriate than food, but monetization is not feasible due to a disincentive effect on local markets;
- When available foods for food aid are inappropriate for dietary needs or cultural conditions.

> "With regards to potential problems of targeting HIV-affected families versus poor but not HIV-affected, there is a risk of stigma especially in areas where HIV sensitization is limited. But in areas where sensitization exists, communities know that people need support. "
>
> -AIDS Service Provider in Kampala, Uganda

ISSUES AND RECOMMENDATIONS

General

Food aid may have a role in assisting PLWHA and affected households and communities to cope with the impact of HIV/AIDS and may be used for two broad purposes: 1) general humanitarian assistance and 2) sustainable food security over the medium and long term.

The finding is qualified by concerns of dependency from and sustainability of using food aid. When moving beyond a short-term activity, food aid should be integrated with longer-term interventions that promote food security and development while fitting within the context of HIV/AIDS care and support.

There are several recommendations that will assist USAID and Cooperating Sponsors create the conditions that assure food aid is most effectively used.

1. Develop food security program guidelines which incorporate the following components:
   - problem analysis that incorporates HIV/AIDS;
   - distinct purposes to which food aid might be applied;
   - using food aid as part of a larger development package;
   - establishing criteria or indicators for targeting food aid;
   - determining the most effective food aid delivery mechanisms;
   - defining appropriate time frames and exit and/or transition strategies;
   - determining when external food aid or local food purchases are most advantageous.

2. Established food assistance and development delivery mechanisms (e.g., FFW, IGA) offer some means to address both HIV/AIDS prevention and mitigation at community levels. However, experience to date with IGAs involving PLWHA is limited and challenges exist in translating experiences from regular development programming to households with PLWHA. In addition, adequate management and material support will be required to assure that IGAs effectively serve PLWHA and affected households.
3. While guidelines for dietary needs of PLWHA do exist; food assistance commodity packages need to be adapted to fit within those guidelines.
4. Targeted food aid may promote greater discrimination where stigmatization due to HIV/AIDS remain high. Both community-wide food assistance interventions and institution-based feeding programs that do not target can reduce the potential for stigmatization of PLWHA and their families.
5. Promote awareness and explore areas where food aid is a useful resource. Utilize the opportunity from recent statements made by leaders in Sub-Saharan Africa about how the HIV/AIDS pandemic has become an emergency and its impact a disaster, to open discussions on the potential uses of food assistance to mitigate future impacts. Improve documentation of pilot and other field experiences with the use of food aid for HIV/AIDS mitigation.
6. Utilize the local networks of organizations to discuss whether and how food aid can be integrated into HIV/AIDS mitigation efforts. Nearly all African countries have responded to HIV/AIDS by establishing institutional units responsible for guiding and coordinating interventions. In the hardest-hit countries, governments, NGOs and CBOs have extensive experience in prevention, care, and support.

Steps to Implement Suggested Interventions

Develop multi-sectoral strategies

1. Develop and implement strategies and programs for using food assistance in "care and support programs" to mitigate the impact of the HIV/AIDS pandemic. This should be done by working with CSs, CAs and Missions to develop programs in support of African AIDS Service Organizations and NGOs. USAID through its bureaus and missions will need to examine the best strategies for integrating development assistance dollar resources with food resources.
2. Work with implementing agencies to develop appropriate reporting mechanisms that will satisfy results reporting and legal requirements. Recognize that targeting individuals, households and communities for food assistance will require flexibility in distribution structures and assumptions about dependency.
3. Assist with the development of indicators to measure the results of these programs. If appropriate, include indicators relating to HIV/AIDS prevalence rates in problem assessments for activities requesting food aid.
4. Explore a wider range of uses for existing monetized food resources. This may include the development of food related IGAs, loan funds to assist households with school fees, and provision of non-monetized incentives for program volunteers.

Strengthen collaboration and partnerships

1. Ensure sustained coordination through a set of regular roundtable discussions between BHR/FFP, G/PHN, and AFR/SD on issues relating to USAID's response to the pandemic, particularly in relation to food security and nutrition.
2. Enhance multi-sectoral responses and resource allocation to the HIV/AIDS pandemic by encouraging food security and HIV/AIDS program officers to hold joint meetings and discussions with other donors, the national AIDS control program, or NGO coalitions.
3. Provide options for utilizing food aid and other food security interventions to mitigate the impact of HIV/AIDS by conducting regional workshops with relevant organizations and stakeholders.
4. Strengthen coordination between and within Title II Cooperating Sponsors (CS's) working in Food Security and AIDS Service Organizations to identify areas of common interest and potential collaboration with food aid.

Increase access to information

1. Establish a communication facilitator (e.g., FAM, FANTA, Global Health Alliance) for linking and sharing experiences related to food security and HIV/AIDS.
2. Support regional networks to disseminate to Missions, CAs, and CSs through general cables or PHN mail listserv information about the research findings, debates, and players involved in food-HIV/AIDS related issues, such as dietary needs of PLWHA, dietary-micronutrient-medication combinations, and replacement feeding for infants of HIV-infected mothers. Some of the networks within Africa involved in disseminating information include: Regional AIDS Training Network (based in Nairobi); Commonwealth Regional Health Community Secretariat (based in Arusha); Afro-Nets, a listserv; Southern Africa AIDS Information Dissemination Service (based in Harare).

Support operations research for improved programming

1. Explore ways that food aid can be used to support community-based prevention and care initiatives, including by involving women and adolescents affected by HIV/AIDS in the planning and management of food aid and IGA activities with AIDS Service Organizations and Title II CSs.
2. Conduct in-depth assessments in Sub-Saharan Africa on the specific food needs of PLWHA and affected households and the approaches to meeting those needs. It is recommended that these assessments be carried out in partnerships with USAID CA's, Title II CS's, and local African agencies (e.g. Southern Africa AIDS Information Dissemination Service based in Harare; Kenya AIDS NGOs Consortium in Nairobi). The results from these assessments can be applied to developing new approaches and tools, such as nutrition tool kits for PLWHA and affected households.
3. Explore, test, and periodically review with service providers and PLWHA means to increase social awareness and sensitivity about HIV/AIDS.
4. Improve targeting of food assistance so households with PLWHA are not stigmatized.